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Mr. Bruce Ramge
Director
Nebraska Department of Insurance
941 O Street, Suite 400
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June 15, 2012

Subject: Essential Health Benefits Analysis

Dear Mr. Ramge:

The State of Nebraska Department of Insurance (State) contracted with Mercer Government Human Services Consulting (Mercer), a division of Mercer Health & Benefits LLC, to assist with the evaluation of current products for their potential to serve as the State's benchmark plan for essential health benefits (EHB), pursuant to the December 16, 2011 Essential Health Benefits Bulletin released by the Center for Consumer Information and Insurance Oversight (CCIIO). This letter provides an overview of the analysis and methodology used to compare four plans that meet the criteria identified in the December 16 guidance.

Mercer's understanding is that the State will use this analysis to support the process of selecting an EHB benchmark plan and gain an understanding of the value and impact of benefit decisions. In addition, the State would like to identify the most cost-effective plan, as determined by a ranking of the benefit levels. Finally, the State would like recommendations on whether the plans are missing significant and important benefits required through the December 16 guidance. This letter presents the findings for the State's consideration in selecting a benchmark EHB plan and may not be appropriate for other purposes. Note that Mercer does not take any opinion with respect to which of the benchmark plan options the State should select. Instead, this analysis is intended to support the State's policy decisions.

Background

As part of the Affordable Care Act (ACA), plans will be required to offer, at a minimum, the State's selected EHB. Non-grandfathered plans in the individual and small group markets and certain Medicaid and other State health plans, both inside and outside of the Exchange, must cover EHB beginning in 2014.

As described in the December 16, 2011 EHB Bulletin, CCIIO studied employer plans in the small group market, state employee plans, the Federal Employee Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association

(GEHA) and suggested the plans do not vary significantly in the range of services covered and appear to cover health services in virtually all of the categories outlined in the ACA.[1] Variation in employer plans is primarily due to differences in cost-sharing provisions, which is not considered in the determination of which plan will serve as the EHB benchmark (and therefore not included in the scope of this analysis).

The guidance clarified that coverage for some benefits varies among the plans studied and further discussed areas with the most significant differences. Specifically, mental health and substance use disorder services are typically offered without benefit limits in the large employer group and State and Federal employee plans due to the Mental Health Parity and Addiction Equity Act (MHPAEA), but small employer plans typically include benefit limits for these services as the MHPAEA does not apply to plans for individuals or groups with less than 50 employees. In addition, the plans studied by CCIIO also vary in the level of pediatric oral and vision services and habilitative services. Furthermore, habilitative services are not well defined in the commercial insurance market, but 70% of small group products offer at least limited coverage for habilitative services, and these benefits may also be covered under the rehabilitative services provision of the plans.[2]

CCIIO has proposed that states define the EHB benchmark to include the scope of services and limits offered by a "typical employer plan" in that state, using the following four types of benchmark plans as a reference:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market
2. Any of the largest three state employee health benefit plans by enrollment
3. Any of the largest three national FEHBP plan options by enrollment
4. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state

States would have the flexibility to select a single plan from existing options listed above to use as the benchmark plan for services and limitations included in the EHB. All ten statutory service

[1] The ten categories of services defined by the ACA include (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services (including behavioral health treatment), (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services (including oral and vision care).
[2] Essential Health Benefits Bulletin, CCIIO, December 16, 2011.

categories must be included as part of the EHB. If the benchmark plan does not cover any one of the required categories, the benchmark plan must be supplemented.

If the State elects to choose a benchmark plan, this must be done by the third quarter of 2012 based on enrollment data and plan coverage in effect during the first quarter of 2012. Should the State be in a position where it is unwilling or unable to make a selection, the U.S. Department of Health and Human Services (HHS) will choose for the State a default plan and has indicated that it "would be the largest small group market product in the State's small group market."[3] Based on the data call from the Exchange work completed in 2011, it would appear that the BCBS BluePride (Option 5) would become the default benchmark plan.

The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in the State. Under the intended approach, a plan must be substantially equal to the benchmark plan in both the scope of benefits offered and any limitations on those benefits, such as visit limits.[4] Because the benchmark plan is taken as is, all of its covered services, limitations and exclusions become the model, subject to any subsequent equivalent substitutions, for all individual and small group health plans offered both inside and outside of the Exchange. Other than supplemental services added per HHS rules, any addition to services within EHB categories not otherwise included in the benchmark plan will not be eligible for federal subsidy and premium sharing.

The December guidance further clarified the states will be responsible for the cost of benefits required by state mandate that are not included in the EHB plan. As such, this is an important factor for states to consider in selecting the plan that will serve as the benchmark for EHB.

In a proposed rule issued June 5, 2012, HHS outlined the data that would be collected to support the definition of EHB and a process related to recognizing entities that would certify qualified health plans. Data to be submitted by relevant issuers include the following:

- Covered health benefits in applicable plans
- Any treatment limitations imposed on coverage

[3] HHS anticipates it will identify and provide benefit information with respect to State-specific default benchmark plans in the fall of 2012.

[4] CCIIO has indicated that flexibility will be given as to specific services covered and any quantitative limits provided plans continue to offer coverage for all 10 statutory EHB categories. This is the same equivalency standard that applies to plans under CHIP. Plans would also be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.

- Drug coverage, including a list of covered drugs and whether each drug is subject to prior authorization
- Plan enrollment data

HHS proposes to require the data described above be collected from the issuers of the three largest health insurance products, by enrollment, in the State's small group market. The rule also proposes to collect information on a voluntary basis from likely stand-alone dental issuers.

HHS is proposing a two-phase approach to recognize accrediting entities to implement the standards under ACA. The proposed rule issued on June 5, 2012 proposed that the National Committee for Quality Assurance and URAC be recognized on an interim basis during the first phase. A criteria-based review process would be adopted through future rulemaking. The clinical quality measures must meet the following criteria:

- Span a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care and acute care
- Include separate measures applicable to adults and children
- Align with the priorities of the National Strategy for Quality Improvement in health care
- Include only measures that are either developed or adopted by a voluntary consensus standards setting body and be evidence based

The data collected, as outlined in the proposed rule, is anticipated to give HHS sufficient information on potential benchmark plans' benefits to know what benefits will be included in the EHB benchmark. As noted previously, the BCBS BluePride (Option 5) is the likely candidate, and as such will be subject to the data reporting requirements described above.

Methodology

Mercer used the following process to evaluate the benefits of different EHB benchmark options for Nebraska:

- Select one plan for each of the four types described in CCIIO's guidance
- Develop a summary of covered benefits and benefit limits for the selected plans
- Identify core and marginal benefits
- Identify missing benefits (i.e., required benefits that are not covered by one or more of the selected plans)
- Evaluate the coverage of mandated benefits in the selected plans
- Measure the premium effect of material benefit differences for the selected plans

Each of these steps is described in further detail below.

Plan Selection

As noted previously, CCIIO guidance allows for the following four types of benchmark plans:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market
2. Any of the largest three state employee health benefit plans by enrollment
3. Any of the largest three national FEHBP plan options by enrollment
4. The largest insured commercial non-Medicaid HMO operating in the state

To identify an appropriate plan for each type to be included in the analysis, Mercer consulted with the State and relied on the Calendar Year 2010 summary of premium and covered lives developed as part of the Exchange planning grant work. Based in part on the findings from that carrier data call in the summer of 2011, the following benchmark plans were selected for further analysis:

1. The BCBS BluePride (Option 5) plan is the largest small group offering in the State.
2. The State indicated the BCBS Blue Choice plan is one of the largest state employee health benefit plans.
3. The FEHBP BCBS Standard Option is widely used in benchmark analyses.
4. Coventry Health Care of Nebraska (Coventry) is one of the largest carriers in Nebraska with any current HMO business. Though Coventry does not actively market HMO coverage, it continues to offer HMO plans for employer groups that request this type of coverage. The State should note that Coventry aggregates its Point of Service (POS) and HMO experience in their reporting and that a vast majority of the HMO premium and covered lives are for POS products. That said, Mercer's understanding is that Coventry is the largest carrier that offers commercial HMO coverage in Nebraska.[5]

[5] Because Coventry does not market HMO plans, it does not have a standard HMO benefit package. The contracts reviewed by Mercer indicated the benefits for the HMO are consistent with the In-network POS benefits. As the only HMO contracts in effect for the HMO products are tailored to group requests, Coventry suggested Mercer apply the "Best Buy" POS benefit limits to the HMO benefits as a proxy for a "standard" Coventry HMO plan (i.e., a plan that would be indicative of an offering if Coventry were to actively market HMO business).

Covered Benefits and Benefit Limits Summary

For the selected plans, Mercer reviewed the marketing materials, contracts and available rate filings to identify the covered benefits and benefit limits. Mercer then developed a summary to highlight the similarities and differences in the covered benefits and benefit limits for the four selected plans. As there is no national standard for the classification of services to the different categories defined by ACA, Mercer assigned benefits covered by each of the four plans identified above to the 10 ACA service categories. Appendix A includes a side-by-side comparison of the covered benefits and limits.

The language used in the marketing materials, contracts and rate filings is not standardized and at times is open to interpretation. Thus, the comparison occasionally required interpretation based on Mercer's experience of industry practices, particularly where benefits were not specifically listed as either a covered or excluded benefit.

Identify Core and Marginal Benefits

Based on the summary in Appendix A, Mercer defined the benefits offered by all plans, even if benefit limits varied, as the "core" benefits and the benefits that were not offered by all the plans as "marginal" benefits. Using this logic, the core benefits are listed below.

Core Benefits with Similar Benefit Limits

- Inpatient and Outpatient Services
- Emergency Services (Emergency Room, Urgent Care, Ambulance)
- Physician Services
- Pre- and Post-natal Care and Delivery
- Laboratory and Radiology Services
- Prescription Drugs
- Health Care Reform Preventive Services
- Mental Health and Substance Abuse (MHSA) Services (Inpatient and Outpatient)[6]
- Renal Dialysis and Home Infusion
- Diabetes Self-management Training
- Mammography and Breast Reconstruction
- Prostate and Other Cancer Screenings
- Immunizations
- Pediatric Services

[6] Though the BluePride plan currently limits MHSA benefits to 30 days of Inpatient and 60 visits of Outpatient services, these limits cannot be applied effective January 1, 2014 for the plan to comply with the federal parity law, as required by ACA.

- Oral Surgery for Accident and Illness
- Home (Durable) Medical Equipment
- Eyeglasses and Contacts (needed as the result of surgery or injury)
- Transplant Services

Core Benefits with Variable Benefit Limits

- Skilled Nursing Care
- Hospice
- Cardiac or Pulmonary Rehabilitation
- Speech, Physical and Occupational Therapy
- Chiropractic and Osteopathic Manipulations
- Skilled Nursing Facility

The limits to the core benefits for each of the selected plans are highlighted in Appendix B.

Marginal Benefits

Marginal benefits are defined as those benefits that are not offered in all of the selected plans. Some of these benefits have a notable impact on a plan's value, while the value of other benefits is not sufficient enough to have a significant impact on the overall value of the plan. Appendix C highlights the marginal benefits for the selected plans. Benefits with a material impact on the plan's value are listed below.

- Tobacco Cessation
- Routine Vision and Hearing Exams
- Routine Dental
- Surgical Treatment of Morbid Obesity (STMO)

Identify Missing Benefits

Habilitative Services

As noted in Appendix A, none of the selected plans specifically identify "habilitative" services as a covered benefit. However, these services are not well defined in the commercial market, and because the "rehabilitative" service provisions for the selected plans do not specifically exclude "habilitative" services, the selected plans may be providing these benefits to subscribers through the "rehabilitative" services.[7]

[7] For the purpose of this analysis, Mercer defined "habilitative" services as those that teach a new skill or function and "rehabilitative" services as those that focus on relearning existing skills or functions. This is consistent with the definition used by Medicaid and described in CCIIO's guidance.

It is worth noting there has been significant discussion regarding the use of habilitative services in the treatment of Autism. Should federal guidance be issued defining habilitative services to include the diagnosis and treatment of autism spectrum disorders, there will be an impact on the value of the EHB in Nebraska, as these services are not currently mandated in Nebraska and are not covered in the selected plans. Estimates for the premium impact of this benefit currently range from 0.0% to 0.3%.[8]

Mental Health Treatment/Parity

As the small employer market is not subject to MHPAEA, the benefit limits in the BCBS BluePride plan are limited to 30 days of Inpatient and 60 visits of Outpatient treatment, even though the Inpatient and Outpatient services for non-MHSA conditions is not limited. However, federal parity laws require that MHSA benefits be subject to benefit limits no less restrictive than non-MHSA conditions effective January 1, 2014. As such, there will be no difference in the coverage for MHSA services in any of the other selected plans and therefore will be no premium impact to consider in choosing the benchmark.

Evaluate Mandated Benefits Coverage

ACA requires states defray the costs of State-mandated benefits that are in excess of the EHB. If the State were to choose a benchmark plan that does not include all State-mandated benefits, the State would have to defray the cost of those mandated benefits in excess of the EHB as defined by the selected benchmark plan. To the extent further guidance allows states to re-select benchmark plan options and an EHB after year 2014 and 2015, any introduction, repeal or modification of the state mandates may be reflected in future construction of the EHB.

Table 1 highlights the State mandated benefits in Nebraska, as defined in Chapter 44 of the Nebraska Revised Statutes (NRS).

[8] Maryland Health Care Commission's "Study of Mandated Health Insurance Services: A Comparative Evaluation," (http://mhcc.dhmh.maryland.gov/healthinsurance/Documents/sp.mhcc.maryland.gov/healthinsurance/mandated_2012_20120106.pdf)

Table 1: State Mandated Benefits Coverage in Nebraska

Section	Benefit	Coverage
44-779	Alcoholism treatment[9]	Covered in all plans except BluePride
44-784	Childhood immunizations	Covered in all plans
44-785	Mammography screening	Covered in all plans
44-788	Off-label use for Cancer, HIV or AIDS drugs	Covered in all plans
44-789	Temporomandibular joint (TMJ) disorder[10]	Limited benefit only in BluePride
44-790	Diabetes self-management	Covered in all plans
44-790	Diabetes supplies	Covered in all plans
44-793	Mental health treatment/parity[11]	Covered in all plans
44-796	Newborn hearing screenings	Covered in all plans
44-797	Breast reconstruction	Covered in all plans
44-798	Certain dental care requiring hospitalization and anesthesia	Covered in all plans
44-7,102	Colorectal cancer screening	Covered in all plans

Temporomandibular Joint Disorder

While surgical procedures to treat TMJ are included in all of the chosen plans, only the BCBS BluePride plan includes additional coverage for TMJ services. Note the additional benefit for TMJ services in the BluePride plan is limited to $2,500 annually. However, as noted in the table above, optional coverage for TMJ treatment is required by §44-789, NRS, but is not covered in the BCBS FEHBP. Therefore, if the BCBS FEHBP plan is selected as the EHB benchmark, the State will be required to defray the costs for optional TMJ coverage. This treatment can involve surgical or non-surgical procedures, and in recent years coverage of it has been valued as low cost, ranging from

[9] The current mandate stipulates only how non-coverage for alcoholism must be disclosed in marketing materials and defines providers for optional coverage; the mandate does not require the provision of services treating alcoholism. Proper disclosure is reflected in the BluePride contract.

[10] The current mandate requires only that TMJ coverage be offered as an optional benefit if surgical and nonsurgical treatment involving a bone or joint of the skeletal structure is covered.

[11] Mental health and substance abuse treatment is covered by all plans selected for review. However, there are limits to this benefit in the BCBS BluePride plan (i.e., 30 days of Inpatient and 60 visits of Outpatient) that will be eliminated under the federal parity law effective January 1, 2014.

less than 0.3% of premium (2004 estimate) to 0.0% of premium (2008 estimate), as noted in the report for the Exchange planning grant work.

Premium Effect of Material Benefit Differences

To measure the impact of material benefit differences for the chosen plans, Mercer actuaries modeled the change in the overall per member per month (PMPM) for core benefits using commercial claims data available through in-house subscriptions. Incremental costs were evaluated for the marginal benefits, where the marginal benefit was expected to have a material impact on the overall PMPM, using continuance tables that describe the claim distributions for the specific benefit.

Results

There are several core benefits with different benefit limits among the selected plans where the benefit limit differences do not have a material premium effect. This is because the benefit is not a significant component of the overall cost or the differences in the benefit limits do not have a material impact on the value of the benefit. In addition, many of the marginal benefits (refer to Appendix C) do not have a material premium effect, as the benefit is utilized with very low frequency. The core benefit differences and marginal benefits that have an immaterial impact on the overall plan (i.e., a premium effect of 0.0%) are listed below.

- Skilled Nursing Care
- Cardiac or Pulmonary Rehab
- Skilled Nursing Facility
- Home Health Services
- Hospice
- Respiratory Care
- Acupuncture
- Family Planning
- Infertility Treatment[12]
- Genetic Counseling
- Sleep Studies
- Hearing Aids
- Wigs
- Speech Generating Devices

[12] The infertility treatment benefit included in the FEHBP plan does not cover assisted reproductive technology (ART) procedures, services and supplies related to ART or infertility drugs used in conjunction with ART.

- Medical Foods

The premium effect for the core benefit limit differences and marginal benefits with a material impact are summarized in Table 2.

Table 2: Premium Effect of Material Benefit Differences by Plan

Benefit	Coventry HMO	BCBS FEHBP	BCBS BluePride	BCBS BlueChoice
Speech, Physical and Occupational Therapy	1.4%	2.1%	2.7%	2.8%
Chiro/Osteo Manipulations	0.9%	0.7%	See note*	See note*
Tobacco Cessation	0.0%	0.1%	0.0%	0.0%
Vision and Hearing Exams	0.0%	0.0%	0.3%	0.3%
Routine Dental	0.0%	7.4%	0.0%	0.0%
Surgical Treatment of Morbid Obesity	0.0%	0.3%	0.0%	0.3%
Total	2.3%	10.6%	3.0%	3.4%

*Note: The BCBS BluePride and BlueChoice plans have a combined benefit limit for speech, physical and occupational therapy and chiropractic and osteopathic manipulations.

Conclusion

Based on the premium effect of the marginal benefits as described in Table 2, the benefit levels of the plans are ranked below in order of the most cost-effective option to the most expensive option.

1. Coventry HMO
2. BCBS BluePride
3. BCBS BlueChoice
4. BCBS FEHBP

In the Exchange planning grant work conducted in 2011, the BCBS Standard Option FEHBP plan was used as a proxy for the EHB plan. Therefore, the projections included in that report would not change if the State were to select this plan as the benchmark. In comparing the BCBS Standard Option FEHBP plan to the other selected plans, we note the premium effect indicates selection of any of the other plans as the benchmark would imply a lower premium than selection of the BCBS Standard Option FEHBP plan. As lower premiums in general should encourage higher enrollment, selection of a lower-cost set of benchmark benefits suggests the resulting Exchange enrollment

could be higher than that projected in the Exchange planning work, if all other assumptions are unchanged.

In our review of the core benefits covered by the selected plans, we believe the benefits are comprehensive and cover virtually all of the required EHB services. However, there is a potential for the EHB premium to increase by 0.0% to 0.3% for the cost of habilitative services related to the treatment of autism spectrum disorders, should federal guidance be issued defining this as a covered benefit in the habilitative service category. The additional cost for this service will be eligible for federal premium subsidy for qualified consumers.

Finally, TMJ coverage is mandated as an optional benefit and therefore the State would be responsible for the costs of TMJ benefits purchased as an option to the EHB. As noted above, TMJ coverage could increase the EHB premium between 0.0% and 0.3%.

While there is clear direction that substitutions to quantitative limits within EHB categories will be permissible, the guidance is unclear as to how flexibility will be given to "specific services covered". Until further guidance is received from HHS, Mercer would advise the State to make its selection with the assumption that services provided by the plan in each of the EHB categories represents the exhaustive list of services that all individual and small group plans will have to offer. HHS has indicated that further guidance on "substitutions" is forthcoming.

Mercer has prepared these projections exclusively for Nebraska Department of Insurance (DOI), to estimate the range of the impact of federal Health Care Reform. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability from the estimates.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the Affordable Care Act and Health Care Education and Reconciliation Act (HCERA) have been issued, including clarifications and technical corrections and without guidance on complex financial calculation that may be required. (For example, some Health Care Reform provisions will likely involve calculation at the individual employee level.) Accordingly, these estimates are not Actuarial Opinions.

Nebraska DOI is responsible for all financial and design decisions regarding ACA and HCERA. Such decisions should be made only after Nebraska DOI's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

Lastly, Nebraska DOI understands that Mercer is not engaged in the practice of law and this report which may include commenting on legal issues or regulations, does not constitute, and is not a substitute for legal advice. Accordingly, Mercer recommends that Nebraska DOI secure the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

The information contained in this document and in any attachments is not intended by Mercer to be used, and it cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

We appreciate the opportunity to assist the State with their analyses and decision-making process related to the selection of the EHB benchmark. Please feel free to call me if you have any questions or would like to discuss further.

Sincerely,

Elizabeth L. Larson

Elizabeth L. Larson, FSA
Principal

cc: John Paul Sabby (NDOI)
Martin Swanson (NDOI)
Stacey Lampkin (Mercer)
Angie WasDyke (Mercer)

Essential Health Benefits Analysis
Benefit Comparison

Affordable Care Act Categories of Coverage	Coventry (HMO)	Blue Cross and Blue Shield of NE (FEHBP)	Blue Cross and Blue Shield of NE (Blue Pride Option 5)	Blue Cross and Blue Shield (State Plan)
Ambulatory patient services	Primary Care Specialist Care Inpatient Professional Home Health Services (60 visit max) Skilled Nursing Care (60 day max, combined with SNF) Hospice	Primary Care Specialist Care Inpatient Professional Skilled Nursing Care (2 hours/day, 25 visits) Skilled Nursing Care (Medicare cost share only) Hospice (up to 7 consecutive Inpatient days, separated by 21 non-Inpatient days)	Primary Care Specialist Care Inpatient Professional Home Health Services (60 day max) Skilled Nursing Care (60 day max) Hospice (60 day max, 30 day max for Inpatient) Respiratory Care (60 day max)	Primary Care Specialist Care Inpatient Professional Home Health Services Skilled Nursing Care Hospice
Emergency services	Emergency Room Urgent Care Ambulance	Emergency Room Urgent Care Ambulance	Emergency Room Urgent Care Ambulance	Emergency Room Urgent Care Ambulance
Hospitalization	Inpatient Outpatient Surgical	Inpatient Outpatient Surgical	Inpatient (including physical rehab) Outpatient Surgical	Inpatient (including physical rehab) Outpatient Surgical
Maternity and newborn care	Pre/Post Natal Care and Delivery	Pre/Post Natal Care and Delivery	Pre/Post Natal Care and Delivery	Pre/Post Natal Care and Delivery
Mental health and substance use disorder services	Inpatient Outpatient	Inpatient Outpatient	Inpatient (30 day max) Outpatient (60 visit max) (no alchoholism treatment)	Inpatient Outpatient
Prescription drugs	Generic, Formulary, Non-Formulary, Specialty	Generic, Formulary, Non-Formulary, Specialty	Generic, Formulary, Non-Formulary, Specialty	Generic, Formulary, Non-Formulary, Specialty
Rehabilitative Services and Devices	Cardiac or Pulmonary Rehab (36 visit max) Speech Therapy (20 visit max) Physical Therapy (20 visit max) Occupational Therapy (20 visit max) Chiro Manipulations (18 visit max)	Cardiac or Pulmonary Rehab Physical, Occupational, Speech and Cognitive Therapy (combined limit of 75 sessions) Chiro and Osteo Manipulations (combined limit of 12 sessions + 1 exam + 1 set of x-rays) Acupuncture (24 visits per year max) Tobacco Cessation treatment and counseling	Cardiac or Pulmonary Rehab (18 sessions) Physical, Occupational and Speech Therapy Chiro and Osteo Manipulations (combined PT/OT/ST/CM/OM limit of 45 sessions with additional combined CM/OM limit of 20 sessions)	Cardiac or Pulmonary Rehab (18 sessions) Physical, Occupational and Speech Therapy Chiro and Osteo Manipulations (combined PT/OT/ST/CM/OM limit of 60 sessions)
Habilitative Services and Devices	N/A	N/A	N/A	N/A
Laboratory Services	Radiology, Laboratory Services	Radiology, Laboratory Services	Independent Laboratory Services	Radiology, Laboratory Services
Preventive and Wellness services and chronic disease management	Health Care Reform required Preventive Services Renal Dialysis Home Infusion Diabetes self-management training Mammography Breast Reconstruction Prostate Cancer Screenings Immunizations Cancer Screening	Health Care Reform required Preventive Services Renal Dialysis Home Infusion Diabetes self-management training Mammography Breast Reconstruction Vision and Hearing Exams (Accident and Illness) Cardiac Stress Tests Prostate Cancer Screenings Immunizations Cancer Screening	Health Care Reform required Preventive Services Renal Dialysis Home Infusion Diabetes self-management training Mammography Breast Reconstruction Vision and Hearing Screenings and Exams Cardiac Stress Tests Prostate Cancer Screenings Immunizations Cancer Screening	Health Care Reform required Preventive Services Renal Dialysis Home Infusion Diabetes self-management training Mammography Breast Reconstruction Vision and Hearing Screenings and Exams Cardiac Stress Tests Prostate Cancer Screenings Immunizations Cancer Screening
Pediatric Services, Including oral and vision care	Child preventive exams, screenings and immunizations	Child preventive exams, screenings and immunizations	Child preventive exams, screenings and immunizations	Child preventive exams, screenings and immunizations

Essential Health Benefits Analysis
Benefit Comparison

Affordable Care Act Categories of Coverage	Coventry (HMO)	Blue Cross and Blue Shield of NE (FEHBP)	Blue Cross and Blue Shield of NE (Blue Pride Option 5)	Blue Cross and Blue Shield (State Plan)
Other Services	Skilled Nursing Facility (60 day max, combined with Skilled Nursing Care) Oral Surgery (Accident and Illness) Organ and Tissue Transplants Home Medical Equipment Eyeglasses/Contacts due to surgery or injury Genetic Counseling Sleep Studies Family Planning (elective sterilization)	Skilled Nursing Facility Oral Surgery (Accident and Illness, includes TMJ) Organ and Tissue Transplants Home Medical Equipment Eyeglasses/Contacts due to surgery or injury Routine Dental Family Planning Infertility Treatment (no ART) Hearing Aids ($1,250 max per ear) Wigs (for cancer patients in chemo, $350 max) Speech Generating Devices ($1,250 max) Medical foods Genetic and Health Risk Counseling Surgical Treatment for Morbid Obesity	Skilled Nursing Facility (60 day max) Oral Surgery (Accident and Illness, includes TMJ) Organ and Tissue Transplants Home Medical Equipment ($5,000 max) Eyeglasses/Contacts due to surgery or injury TMJ ($2,500 max)	Skilled Nursing Facility Oral Surgery (Accident and Illness, includes TMJ) Organ and Tissue Transplants (includes auto) Home Medical Equipment Eyeglasses/Contacts due to surgery or injury Surgical Treatment for Morbid Obesity Sleep Studies

State of Nebraska
Department of Insurance

Essential Health Benefits Analysis
Core Benefits Summary

Core Benefits - variable benefit limits	Coventry (HMO)	Blue Cross and Blue Shield of NE (FEHBP)	Blue Cross and Blue Shield of NE (Blue Pride Option 5)	Blue Cross and Blue Shield (State Plan)
Skilled Nursing Care	60 days	2 hours/day, 25 days	60 days	no limit
Hospice	no limit	7 consecutive IP days, separated by 21 non-IP days	60 days (30 days for IP)	no limit
Cardiac or Pulmonary Rehab	36 visits	no limit	18 sessions	18 sessions
Speech Therapy	20 visits	75 visits, combined with PT/OT	45 visits, combined with PT/OT/Chiro	60 visits, combined with PT/OT/Chiro
Physical Therapy	20 visits	75 visits, combined with ST/OT	45 visits, combined with ST/OT/Chiro	60 visits, combined with ST/OT/Chiro
Occupational Therapy	20 visits	75 visits, combined with ST/PT	45 visits, combined with ST/PT/Chiro	60 visits, combined with ST/PT/Chiro
Chiro and Osteo Manipulations	18 visits	12 visits plus 1 exam and 1 set of x-rays	20 visits, combined with ST/PT/OT	60 visits, combined with ST/PT/OT
Skilled Nursing Facility	60 days, combined with Skilled Nursing	no limit	60 days	no limit

State of Nebraska
Department of Insurance

Essential Health Benefits Analysis
Marginal Benefits Summary

Marginal Benefits	Coventry (HMO)	Blue Cross and Blue Shield of NE (FEHBP)	Blue Cross and Blue Shield of NE (Blue Pride Option 5)	Blue Cross and Blue Shield (State Plan)
Home Health Services	60 days	Not Covered	60 days	no limit
Respiratory Care	Not Covered	Not Covered	60 days	Covered
Acupuncture	Not Covered	24 visits	Not Covered	Not Covered
Tobacco Cessation	Not Covered	Treatment and Counseling	Not Covered	Not Covered
Vision and Hearing Exams	Not Covered	Accident and Illness Only	Routine	Routine
Routine Dental	Not Covered	Exams, x-rays and restorations	Not Covered	Not Covered
Family Planning	Birth Control and Voluntary Sterilization	Birth Control and Voluntary Sterilization	Not Covered	Not Covered
Infertility Treatment	Not Covered	Diagnosis and Treatment (no ART)	Not Covered	Not Covered
Genetic Counseling	At risk populations only	At risk populations only	Not Covered	Not Covered
Surgical Treatment of Morbid Obesity (STMO)	Not Covered	Gastric Restrictive Procedures	Not Covered	Gastric Restrictive Procedures
Sleep Studies	Prior Authorization Only	Not Covered	Not Covered	in conjunction with STMO
TMJ	Not Covered	Not Covered	$2,500 max per year	Not Covered
Hearing Aids	Not Covered	$1,250 / yr per ear for children $1,250 / 3 yrs per ear for adults	Not Covered	Not Covered
Wigs	Not Covered	$350 per wig, 1 wig per lifetime	Not Covered	Not Covered
Speech Generating Devices	Not Covered	$1,250 max per year	Not Covered	Not Covered
Medical Foods	Not Covered	Administered by Catheter or Nasogastric tube	Not Covered	Not Covered